PATIENT 1st COMPLAINT/GRIEVANCE FORM

**Note: for reporting complaints regarding Patient 1st Providers Only*

Mail the completed, ***signed*** form to: Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Name of Person Completing this Form: _____
(May be the recipient, designated friend/family member, medical provider, hospital, community member, etc.)

Date Form Completed: _____ Relationship to Recipient: _____

Recipient Name: _____ DOB: _____

Medicaid Number: _____ County of Residence: _____

Address: _____

Telephone Number:_____

Name of Doctor: _____ Practice: _____

Please describe your complaint in detail including dates/names: (please attach any additional documentation)

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Over (See Consent Statement and Signature)

PATIENT 1ST COMPLAINT/GRIEVANCE FORM

Patient 1st staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **Please do not sign both statements.**

1. **If you agree to allow us to use your name in investigating this complaint, please sign the following:**

I give the Patient 1st staff permission to use my name when sharing my complaint with the Primary Medical Provider (PMP) named in my complaint. The PMP has my permission to respond to the Patient 1st staff concerning my complaint and release medical records regarding the patient when necessary.

_____ _____
Signature of Complainant Date

_____ _____
Signature of Patient/Parent/Legal Guardian Date of Birth

OR

2. **If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:**

_____ _____
Signature of Complainant Date

_____ _____
Signature of Patient/Parent/Legal Guardian Date of Birth

If you have any questions regarding the use of this form or the Patient 1st complaint process, please contact the Patient 1st Program in Montgomery at 334-353-5907. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

Patient 1st PMP Name: _____ PMP# _____

Patient 1st Practice Name: _____

County Where Patient 1st Practice is Located: _____

Comments: _____

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